Reimbursement Plan

Enrollment and Change Form

Coverage Type

- ☐ Employee Only
- ☐ Employee + 1 Dependent
- ☐ Employee and Family
- ☐ Spouse Only
- ☐ Family – Dependents Only

Check appropriate options

- ☐ New Enrollment Hire Date: _____
- ☐ Open Enrollment
- ☐ Qualifying Event –circle qualifying event

Marriage Divorce Birth Loss of Coverage
Gain Coverage Other_____

Enrollment due to a qualifying event requires proof validating the event

Copy of Primary Insurance Card must accompany this completed form at time of enrollment.

Complete Employee Information

- ☐ Board of Education Employee
- ☐ County Government Employee

Indicate the Department or School Location where you work: _____

Work Phone: _____ Home ***or*** Cell Phone: _____ Male or Female

Employee Name: _____ SS #: _____ Date of Birth: _____

Address: _____City: _____ State: ____ Zip: _____

Please list all family members to be enrolled or terminated

First, M.I., & Last Name	SEX	Social Security #	Birth Date
SP	F M	- -	- -
CH	F M	- -	- -
CH	F M	- -	- -
Ch	F M	- -	- -

By signing below, I agree to all terms and conditions of enrolling in and continued enrollment in the Williamson County Medical program, as such exist on the date of my enrollment as reflected below, and as such may change from time to time, with or without notice to me. I further represent and warrant that all information given by me is accurate, current and complete to the best of my knowledge. I agree to allow the Williamson County Benefits Department to have the appropriate deductions taken from my paycheck according to my above enrollment options.

Employee's Signature: _____ Date: _____

Williamson County Benefits Department use only:
EE Hire Date: _____-_____-_____ Effect Date of Enrollment: _____-_____-_____
12/29/2008